Macdonald (A. E.)

A LECTURE

DELIVERED BEFORE THE PUPILS

OF THE

SCHOOL FOR NURSES,

CHARITY HOSPITAL, N. Y.,

OCTOBER 6th, 1875,

ON THE

NURSING OF THE INSANE,

BY

A. E. MACDONALD, M. D.,

MEDICAL SUPERINTENDENT, NEW YORK CITY ASYLUM FOR THE INSANE;
LECTURER ON MEDICAL JURISPRUDENCE IN THE UNIVERSITY
OF THE CITY OF NEW YORK.

BELLEVUE PRESS:
1875.

Dr. Macdonald's
COMPLIMENTS.

Department of Public Charities and Correction.

ISAAC H. BAILEY,
THOMAS S. BRENNAN, } Commissioners.
TOWNSEND COX,

DANIEL H. KITCHEN, M. D.,

CHIEF OF STAFF,

CHARITY HOSPITAL.

SCHOOL FOR NURSES,

CHARITY HOSPITAL, B. I.

THE NURSING OF THE INSANE,

A LECTURE BY

A. E. MACDONALD, M. D.

The presentation of the duties and responsibilities of a nurse in the care of patients suffering from the various forms of disease to which flesh is heir, has, no doubt, been made by the gentlemen who have from time to time preceded me, with sufficient fullness and accuracy, to convince you that the career you have chosen is one entailing no small degree of labor upon, and requiring no small degree of faithfulness from, any one who would conscientiously and successfully pursue it. When I tell you that in the care of the unfortunate class of sufferers of whom it is my duty to speak to you, all those qualities which combine to fit a nurse for the care of ordinary cases of disease will be doubly needed and doubly taxed, it is not with any design of causing you discouragement, but with the view of impressing upon you the importance of this special branch of your calling. Despite the very natural and pardonable tendency of physicians to exalt that particular branch of their profession to which they more or less exclusively devote themselves, I do not question that each one of these gentlemen will readily admit that in the care of those in whom disease manifests itself, not alone in disturbance of the functions of the body, but of the functions of the mind also, the judgment, skill and patience of the nurse will, more than in that of any others, be tested and exercised.

I do not know under just what divisions your duties have been described to you, but no doubt, among other

important branches treated of, the nutrition and protection of the patient have been duly touched upon. Take these two branches, for example—and the same remarks apply with equal force to all—and you will see at once how much graver an importance they assume, when the subject of your care is insane instead of sane. In the matter of nutrition, weight has probably been chiefly laid upon the method of preparation of the food and of serving it. The patient himself has been treated of as an efficient ally—anxious to meet you half way in all your measures for his comfort and cure, and if he has formed the subject of direct remark at all, it has probably only been in reference to the capriciousness of his appetite, or some equally trivial detail. But with the insane, while such considerations retain all their original importance, we have the added gravity, which a patient who is not disposed to meet us halfway imposes. Not only must the proper quality and quantity of the food, the manner of its preparation, and the hours of its administration be duly considered, but the fact that, as likely as not, the patient will oppose all efforts to induce him to eat. In the matter of the protection of patients, warnings have probably been given as to such comparatively simple and preventible dangers as exposure to draughts, accumulation of discharges, and so forth. With the insane the question of protection is one of very gravest importance. There is a general and constant danger of suicide or self-inflicted injury, and an utter absence of all personal precautions. In a word, the sane patient, as a general rule, appreciates his condition, is anxious to recover, and does his fair share toward the completion of any measures that may be prescribed for him. With the insane patient it is entirely different. Either he does not recognize and acknowledge the fact that he is sick at all, or else he considers himself utterly and hopelessly so, and in either case, though from different motives, he passively or actively opposes all your efforts. It is not many years since any instructions to *Nurses* regarding the care of the insane would have been regarded as entirely uncalled for; since, indeed, the nurse had nothing to do in the matter of such care. But of late insanity has come to be better understood by all classes. It is known now as a disease, not as the evidence of demoniacal possession, and, with the change in the belief as to its nature, has come an equally decided change in its treatment. The chains with

which the madman was confined, the tortures with which he was visited, have vanished, and in their place we have all that the tenderest humanity can prompt, and the most advanced science indicate.

But something of the evil repute which justly attached to the old mad-house, still clings to its more modern and more beneficent representative, and to the prejudice in the popular mind which finds its origin in tradition, and its perpetuation largely in the fictions of sensational novelists and the like, you will owe it that you may be frequently sought to undertake the care of the insane.

As a general rule the insane can be much better cared for in institutions exclusively devoted to their reception than in an ordinary dwelling and among familiar surroundings. But there are undoubtedly many cases in which removal to an asylum is unadvisable, and to this number the prejudice I have mentioned adds many others, and thus cases of insanity will be not unfrequent among those of whom you may be asked to assume the charge. The nurse who attends upon cases of child-birth will have a patient with puerperal insanity now and again, and such patients will commonly, and very properly, be retained and treated at their homes, at least in the earlier and more acute stages. So, too, in other cases, in which the disease is acute, and the indications are that its course will be speedily run. If recovery may be looked for in a short time, and circumstances render the retention and treatment of the patient at her home practicable, it is well to spare her and her family the reproach which popularly, though unjustly, clings to one who has been in an asylum. Then there are people who will utterly refuse to permit the removal of an insane relative, and in such cases it will be the duty of the physician and the nurse to do everything that is possible in the interest of the patient, after the former has duly warned the family of the risks that they incur, and so relieved himself from any responsibility for their course and its consequences.

It will not be necessary for me to enter into any very elaborate description of the disease which we call insanity, or to enlarge upon its various forms and manifestations. It will suffice if I impress upon you the fact that it *is* a disease—and a disease not of the mind, as it is commonly termed, but an actual physical malady. The interruptions and distortions of the working of the mind, the disturbance

of thought, the singularities of speech and action, are merely the symptoms. The disease is in the brain, and, that being the organ of the mind, the mind, of course, gives evidence of its effects. Hence it follows that you are to regard the abnormalities of conversation and conduct as the evidences of the disease, to absolve the patient from all responsibility for them, and, above all, to refrain from any display or feeling of resentment at them, and it follows also that the cure of the malady is not to be compassed by any efforts directed toward these abnormal manifestations, except as entirely secondary measures, but by the exercise of those attentions which are called for by a tangible physical disease.

As to the forms of the disease, I need only say that it will commonly present itself to you in one or other of two aspects—either there will be a departure from the normal and ordinary condition in the direction of exaltation, or of depression. These constitute the two forms of mental alienation, to which the technical names "mania" and "melancholia" have been given. For convenience sake, I shall employ these terms in speaking to you. The only other technical terms, I shall use—and those only because there are no ordinary equivalents which fairly represent them—are "delusion" "illusion" and "hallucination." By a delusion we mean a false belief. The subject of the delusion believes something to be a fact, which is not really so, and he cannot convince himself, nor can you convince him of his error. An illusion is a mistake in perception, an object presented to one of the senses is transformed into some other object. An hallucination is also a mistake in perception, but with the difference that there is nothing to start from. The man, who, hearing a certain sound, believes that he hears another, and different one, has an illusion. But if he fancies he hears a sound when there is none at all, it becomes an hallucination.

In the case of a patient with insanity of the maniacal type there is, as I have said, general exaltation, general excitement. He is very talkative, very noisy. He moves rapidly about, singing, laughing, shouting by turns. He is destructive of clothing and furniture, and apt to be violent toward those about him. He is sleepless, dirty in his habits, and preserves the same restless activity through the whole course of his disease, which is of necessity terminated in one way or another, after a comparatively short duration.

Where the form of insanity is melancholia, there is depression instead of exaltation. The patient is utterly cast down and overwhelmed. If he moves about, it is with the design of escaping from some danger that is impending, or some enemy who is pursuing him. He is not noisy, and his countenance, instead of betokening excitement, or rage, shows only grief, fear and despair. He is not ordinarily dangerous to others, but he is always apt to injure himself, to the extent even of self-destruction.

These are the more prominent features of the two forms, in which insanity will present itself to you. Of course, they are not always, or often, so sharply out-lined, or so distinct, one from the other. Sometimes they approach so nearly, as to be with difficulty distinguished, and occasionally they alternate in the same individual.

That the Nurse's duty must differ somewhat as the cases differ, will be obvious. In the one it will lead her to soothe, moderate and restrain. In the other, to rouse, stimulate, and cheer. If your patient be maniacal, boisterous, noisy; your demeanor should be such as to exert a counteracting effect upon her; your movements should be quiet and deliberate; your speech low. If, on the other hand, she is cast down, your manner should be brisk, and your conversation lively and pleasant. Undue hilarity is to be avoided, of course, but cheerfulness is to be cultivated.

As regards the patient's delusions, and your behavior in reference to them—my advice to you is to avoid them as much as possible, but never to admit their truth. One is very apt to think that it will humor the patient, and help to make things go along easily, and pleasantly, to acquiesce in her false beliefs, and even go so far as to strengthen them, by acting a part in accordance with them. But this is very far from being the case. Nor is it advisable, on the other hand, to contradict or ridicule them. It is about as much use to try to argue a diseased brain back to health, as a diseased stomach. We do read of striking cases, where a resort to ridicule, or an ingenious argument, has suddenly, scattered the diseased fancies, and brought the patient back to sanity. But we do not meet these cases in our own experience. The condition of mind, which renders it capable of supporting the delusion, renders it also incapable of appreciating the proofs, whereby you would demonstrate the fact that it is a delusion. On the other hand, to appear to admit, either

specifically, or by your conduct, that delusion is truth, is sure to eventually lead to your embarrassment and confusion. Say, that the patient believes herself to be in excellent health, possessed of enormous strength, you coincide with her, and a short time afterwards, you endeavor to administer some medicine to her, and you will see at once, that your position is illogical. She will see it also, and resist, and your trouble will commence. A middle course is best in such cases. Do not notice or interfere with the statement of the delusion, if you can avoid it. But, if it is forced upon you, say plainly that you cannot agree with the patient—cannot view the thing as she does, nd think she must be mistaken. Let the matter rest there, and do not allow yourself to be drawn into an argument. You will not have convinced the patient of her error. She will go on clinging to her delusion, and pity your ignorance or blindness. But at least you will not have placed yourself in a false position towards her. So with hallucinations and illusions. Never be led to feign the ability to hear, or see, or smell things that present themselves to the perverted senses of the patients, and are not perceptible to your own. If there were no other reason for the course which I advise, the consideration of the patient's possible recovery would supply one. How much easier will it be for her, in her convalescence, to shake off her delusions, if they have not had your testimony in support of them? And how much better will be her feeling toward you if she does not find, with returning reason, that you have deceived her?

Your main object should be to gain the confidence of your patient. Do this, and you will have much more of comfort and ease in your attendance upon her, and much more of success in carrying out the measures necessary to her recovery. You will then find her more docile, more willing to follow your directions, and also, your safety from any personal attack will be enhanced. With the friends, also, your relations will be placed on a better footing, if they find that the patient relies upon you, and is easily controlled by you. One thing that will help you to gain this confidence, will be the fact that you will, in all likelihood, be a stranger to her. You will find that with the insane, there is a common distrust of, and dislike to, their own kin. From this feeling you can derive advantage, without of course encouraging it. An important point is never to manifest the slightest fear of your patient. If you

have any such fear, it will be better to decline the task of caring for the insane. At any rate, you should conceal it carefully in their presence. They are very quick to detect evidences of such weakness, and to take advantage of it, while for one who is cool and self-possessed and shows no signs of trepidation, they have a very wholesome respect. For the rest, much will depend upon your manner and your conduct. If the one is frank and open, and the other, natural and unembarrassed, they will go far to allay suspicion. If, on the other hand, your countenance has a disingenuous look—your eyes avoid the patient's, and you are given to whisperings in corners, and mysterious movements, you need not wonder if the patient's morbid distrust be excited, and she sets you down as a co-conspirator against her life and property.

It will follow from what I have already said in favor of candor and honesty in your intercourse with your patients, that I should strongly advise you against any shadow of false pretence in the character in which you present yourself to her. Have it perfectly understood, that you are a Nurse, and she a patient. That you are there, because she is sick, and you are to take care of her, and let there be no deception as to your relations one to the other, or as to the meaning of your advent. This is a point upon which the natural injudiciousness and obstinacy of the relatives of the insane, are particularly likely to assert themselves. They are inflexibly opposed to any course which will entail a recognition of the fact that their relative is in ill health, and they will acquiesce with her in any fancy, however extravagant, which may suggest a means of avoiding the confession. They will even go further, and devise some choice little fiction themselves, and you will be told that your patient imagines herself a queen, and so you must personate a maid of honor, or you may be called upon to assume the role of a governess, or a lady visitor, or what not. They seem to revel in such clumsy comedies, and to be perfectly oblivious to the painful incongruities which attend them, and they will look on with irrepressible gravity, and many a smirk of self-conscious ingenuity, while the governess gives a lesson to an old woman, or the maid of honor feeds the queen with a stomach-pump. I cannot too strongly advise you to be no party to such masquerading. It will put you in a false position from the first, hinder and embarrass you in the performance of all

your legitimate functions, and give you infinite labor and trouble. The fancies of the insane are by no means persistent, rather they are undergoing constant change, and if you once commence this sort of thing, you may have to change your character a dozen times in a day. How much better to preserve always a character which can never become ridiculous, between which and the surroundings and the necessities of the patient there can be no incongruity, and to avoid a species of private theatricals, which, in the presence of disease, and the possibility of death, assume a very ghastly humor.

Never be tempted by the strangeness of your patient's fancies to encourage the telling of them; never "draw her out," as it is called; and, especially, never ridicule and make jest of them, whether in her presence or in conversation with others.

One of the strongest reasons for sending insane patients to asylums, is that they will thereby be removed from daily and constant intercourse with the members of their family, and their friends. Consequently, one of the greatest drawbacks you will have to encounter, when the patient is retained at home, will be the fact that this intercourse must exist to a greater or less extent. It is characteristic of insanity that it shows itself prominently in an entire subversion of the natural feelings. Those whom a man has most dearly loved and trusted, while he was in health, are just those toward whom he shows the greatest distrust, resentment and hatred, when his reason is overthrown. Those whom his disordered fancy tells him are conspiring against him, to ruin or murder him, are not strangers or acquaintances, but his wife, his mother, or his children. So it is obvious that to put him on the way to recovery, it will be important to remove from his sight, those who are most nearly related to him. Not only consideration for him, but for them, would prompt this, for to witness the change in his conduct and his affections must, of necessity, be very painful to them, and in insanity, if not indeed in sickness generally, relatives as a very general rule, are far from making the most judicious and trustworthy attendants. The wisdom of withholding from the patient's sight, persons who only incense and excite him should, one would think, be evident to the common sense of any one. But, unfortunately in the case of the relatives of insane persons, common sense is very largely in abeyance. Nothing is

more difficult than to persuade a wife, for instance, that her place is not by her husband's bedside. He is sick, and who can attend upon him more faithfully and more tenderly than she? The physician will, no doubt, make it one of the conditions of the patient's remaining at home, that his family shall abstain from seeing him, save at infrequent times, and under proper restrictions. But it will largely fall upon you to enforce his instructions, and this will need all your tact and firmness. It is very horrible, no doubt, but there *are* people who think that Doctors are capable of being mistaken, and others who think that Doctors are hard-hearted, and they will appeal to you, and cajole you, and try to get you, in a quiet way, to ignore your instructions, and admit them. Of course you must, for your patient's and your own sake refuse them, as mildly and courteously as may be, but with decision and firmness, that will admit of no appeal. Baffled in this, they will want you to act as their agent, to speak to your patient about some certain subject, to ask some certain question. In this also your refusal should be definite, though polite. Your communications with the family should be frequent, and your reports as encouraging as possible. Naturally, they will be anxious, and wish for all the details. Your statement to them should be frank, but very full descriptions of the patient's behavior, or repetitions of her remarks, are to be avoided. They are unnecessary, will grieve your questioner very often, and may do no little harm. When persons are admitted to see the patient, regulate their conduct, so far as you can, by example and precept also. Deprecate any display of emotion, or anything that is calculated to excite or depress the patient. Be careful to say nothing yourself, and, so far as you can, prevent others saying anything, that it is not perfectly advisable that the patient should hear. People are very apt to think that, because an insane man is incessantly talking himself, he is paying no attention to the remarks of others. This is a mistake. Equally is it a mistake to think that because a patient's face looks absent and distraught, he is not keenly alive to what is being said by those about him. You will often be surprised to find how accurately the insane will remember, and how ingeniously they will distort chance conversations, which have been carelessly conducted in their hearing. So, if anything is to be said concerning the patient, don't let it be said aloud. And don't let it

be said in a whisper either, for the insane are always suspicious and distrustful, and when two people get together in a corner and whisper to each other, with mysterious glances at the patient, she is sure to conclude that some plot is hatching of which she is to be the victim. In short, don't hold such parley in the patient's presence at all.

One caution to you in relation to your intercourse with the patient's friends: never let them tempt you to express an opinion as to her prospects of a recovery. That is a question which it is peculiarly within the physician's province to answer. Your opinion will be asked in many different ways: How does this case resemble others that you have attended? and what was the course and the termination in such cases? In whatever form the question is presented, be careful to forbear to answer it.

An important duty which you will owe to your patient is to preserve silence respecting her. You are to regard the utterances of her delirium as confidential disclosures, and must never repeat them. The traditional skeleton which is to be found in every household is very apt to be uncovered in the ravings of the delirious, and the thoughtless repetition of what may have appeared to you as but a senseless fancy, may prove the cause of no little annoyance and anxiety to the patient's family and friends, and to the patient herself, should she recover. The relations of the physician to his patient in this regard are generally recognized as of sufficient importance to form the subject of legislative enactments, and in the restrictions which are thus imposed a higher authority still—public opinion—coincides. The laws of our own State, for example, provide that "No person duly authorized to practice physic and surgery, shall be allowed to disclose any information which he may have acquired in attending any patient in a professional character." This prohibition, as with other of the duties and responsibilities of the physician, applies with equal force to you. You will, doubtless, find yourselves tempted more than once to relate your experiences at the bedside of those whose minds are wandering. Their ravings are so droll, their actions so fantastic. Think of them always as the external evidences of grave disease, and the drollery will be less striking. Even toward the family and friends of the patient should you preserve this reticence. It is quite possible that she may reveal secrets of her own which in health she has seen fit to keep from them,

and, at least, she is more than likely to say things respecting them at which they, forgetting that they are but the irresponsible ravings of a disturbed mind, may take umbrage or feel pain. The only exception to the silence which your relation to the patient imposes upon you, must be in favor of the physician. To him her sayings should be repeated, or their substance indicated, for in them he may find some guide to the cause of the mental alienation, or some warning of a disposition to suicide or other danger.

I have told you that in certain insane patients the danger of suicide is always imminent. As you would doubtless expect, this danger is principally to be looked for in those patients in whom the disease assumes the form of melancholia. As a general rule the maniacal patient is apt to commit homicide, and but little likely to commit suicide; on the other hand, with melancholia patients, suicides are frequent, homicides uncommon. All patients with melancholia do not commit suicide, nor do all attempt it, but there are very few to whom the thought does not at some time present itself, who do not at some time feel the inclination to self-destruction more or less forcibly impelling them. Patients who have gone through an attack of melancholia to recovery, when questioned upon the matter will, with very few exceptions, acknowledge that the idea of suicide occupied their thoughts at one or other period of its course. So it will be safe to look upon every patient as a possible suicide, and govern yourself accordingly.

First there must be unrelaxing watchfulness. Do not allow yourself to lapse into a feeling of security because a few days or weeks have passed and the apprehended danger has not shown itself. Perhaps the impulse has only been delayed, and may manifest itself at any moment, or possibly the impulse has been constant and the act has failed to follow, only because particular means have not yet presented themselves. This is a peculiarity about the suicides of the insane, and one that it will be important for you to bear in mind. The impulse is not commonly to the commission of suicide blindly, through any agency that may be at hand. Oftener it is to the commission of suicide in a certain manner and through specific agencies. A man may allow weapons or poisons to lie at his hand untouched, and wait until he gets an opportunity to throw himself from a window, or he may walk by a river for hours, and then

retire from it to hang himself. The patience with which the insane will wait until certain conditions favorable to self-destruction present themselves, and the cunning with which they will scheme to bring these conditions about are remarkable.

Hitherto I have spoken of those in whom the suicidal design is deliberate, but there are others in whom the impulse is instantaneous. In these cases the thought is often suggested by the sudden sight of the means of accomplishment. Thus a patient who has never manifested any suicidal tendency will have it forced to sudden activity and sudden accomplishment by the sight of a sheet of water or a cliff, into, or from which he may precipitate himself. Some of you, upon looking down from a lofty building or a bridge steadily for a few moments, have felt an almost irresistible impulse to cast yourselves into the street or the stream below. Just such, but more powerful, is the impulse that comes to the insane at sight of the means of self-destruction. Such suicides are frequently the result of hallucinations, and in those which have that origin the motive is not always to destroy life. Often the patient has no such idea. He refuses food, because he thinks he can and must fast for forty days, and live, as did our Saviour; or he throws himself from a window, because he believes that he will float upon the air. So you will see that the mere fact that a patient is cheerful, and displays no suicidal inclinations, is no security that the danger of self-destruction is absent.

Of course the removal of all dangerous articles from the room will occur to you as a proper and necessary precaution, and this should include not only such articles as are always dangerous, but such as could in any way, by ingenuity or determination, be rendered so. And when you have done all this, you will still have left behind more than one means of self-destruction. The bed-clothes will always furnish ropes; a piece of window pane can be made to cut a throat, or open an artery; more than one insane person has drowned himself by thrusting his face into a basin full of water; and I have seen a well-nigh successful attempt at suicide made with a common pin. So I say to you again, that constant vigilance is the only efficient safeguard. Suicides are commonest early in the morning, at meal times, and after dusk, but the vigilance should not be relaxed at other times, only, if possible increased at these.

Of course windows should be fastened down, and open fires forbidden. A means of suicide that must be strictly guarded will be found in the medicines that may be prescribed for the patient. Unless these are known to be harmless, they should not be kept in the room, or, if they are retained there, should be safely put under lock and key, and the key put in the Nurse's pocket. I know that the good Nurse takes somewhat the same pride in the sight of the medicines, which it is her duty to administer, as the good workman in any branch of industry, takes in the tools of his craft, and the neat little table with the white cloth, and the group of bottles and spoons which she loves to place at the head of the bed, is a very refreshing sight, no doubt, to herself, and the Doctor, though it is perhaps less a thing of beauty and a joy forever in the eyes of the patient. I am sorry to deprive her of the means of exercising such a pardonable and commendable pride, but, if the patient happens to be an insane one, I think the little table, or at least its contents, had better be banished, or there may come a time some fine morning when the Nurse shall betake herself and her bottles elsewhere, after she has told the Coroner the truth, the whole truth, and nothing but the truth.

When you have arranged for the security of the medicines in the intervals of their administration, you must see that they go to their proper destination at the time of administration. If you give a patient an opium pill, make sure that she swallows it, and that she does not save it up, and add other opium pills to it, until she gets opium enough to take her out of the world. With liquid medicines the danger is less, but still there is a danger, and cases have been recorded where the patient retained the fluid in his mouth until the Nurse's back was turned and then ejected it into some utensil, and repeated this with successive doses until a quantity sufficient to cause death was obtained. Watch for the movement of the ball of the throat, which indicates the act of swallowing, and if you don't see it, make the patient open her mouth. If she won't do this, press the nostrils gently together, so as to prevent the entrance of air by that passage, and in a few moments, the necessities of respiration will come to your aid, and the mouth will be opened and the fluid swallowed.

If the suicidal determination is plainly shown, the patient must be restrained, but yet all danger will not be averted.

You may confine her arms with a strait-jacket, but still she may throw herself from a window, or dash her head against the wall; or you may tie her in her bed and she will strangle herself with the very cords you use to secure her. So, when everything else is done, the necessity for close supervision is as great as ever. Finally, let nothing induce you to leave the room for an instant, unless some one takes your place. No matter what the inducement; even though it be the Nurse's nectar—a cup of tea. It is the history of most suicides, that they have been committed when the Nurse had "just stepped out for a minute." A minute—especially one of the length which is generally implied when that excuse is offered—is ample time for the commission of suicide a dozen times over. I have known a knife to be drawn across a throat, and a life sacrificed, where two attendants stood close, one on either side of the patient, and did not have time to raise their hands.

I pass now to the consideration of the special difficulties and special necessities, which, in the care of insane patients, attend the administration of food and of medicines, and in taking up this branch of my subject approach, perhaps, its most important aspect. In no disease is there greater depression of vital energy, and greater expenditure of muscular force than in insanity. Hence the eminent importance of their constant and complete replenishment. In mania, at the outset, the patient may be in good physical condition, and of robust health, but the exhausting struggles, the violent excitement, the consumption of nervous power, will in a very few hours tell upon the system, and, unless the strength be kept up by sufficient nourishment, death must speedily ensue. In melancholia, on the other hand, the patient is usually in poor condition at the outstart, and the disturbance of the digestive functions which ordinarily complicates it, and the mental vagaries which render the patient your indifferent ally, or your determined opponent, at once add to the necessity of generous nutrition, and render it difficult of accomplishment.

You will find less difficulty, as a rule, in securing the consumption of a sufficient quantity of food by the maniacal, than by the melancholic patients. Their appetites will be capricious perhaps—at one time they will not eat at all, at another they will devour everything within their reach; but, day in and day out, they will eat a sufficiency, and often they will eat enormously. So there will not be much

trouble to persuade them to eat,—rather you will have to guard against their over-eating, or their eating improperly. They are apt to eat voraciously, seizing their food in their hands, "bolting it," to use an expressive term, without any mastication, and behaving generally more like the lower animals than like human beings. So there is danger in the first place of choking, and in the second place of such a hasty and excessive engorgement of the stomach that it will rebel, and rejecting its contents by vomiting, the value of the meal may be lost. The food therefore should be specially prepared, meats cut up in small pieces, proper seasoning supplied, and the different articles which it is deemed best to give, mixed, so far as practicable, upon the plate. Then too much should not be placed before the patient at a time, so that her rapidity of swallowing may be, to some extent, corrected.

It is quite possible that the maniac may have delusions which will deter her from eating, but they will be unlike those of the melancholic which prompt to the same abstinence, and of which I shall speak presently. Such delusions in the maniac partake of her general exaltation. Food is unnecessary to her she imagines, for her strength is beyond the strength of men, and she can live without food, and yet exercise her power in the performance of the most wonderful feats. Such delusions are not, however, commonly persistent. It is of importance to remember that maniacs are often very sly and cunning, and that they will frequently refuse food if you offer it to them, and take it greedily when your back is turned. They are like certain young ladies who have very delicate appetites in company, and empty the pantry in private. They seem to hold to the truth of the old saying, that "stolen fruit is always the sweetest," and they will chuckle over a meal which they fancy they are gaining clandestinely. So it will be justifiable sometimes to affect ignorance of their movements, and to allow them to think that they are helping themselves without your privity. I have known a patient to regularly refuse food that was placed upon a table, and to which she was invited in the usual way, and to as regularly help herself from the cupboard, where a supply was always *accidentally* left for her. Don't be in haste then to remove food that a maniac has refused to eat, just because she *has* refused it. Give her time to change her mind, and opportunity to partake apparently unobserved. It may

not be that her refusal is the result of delusion—she may be too busy discussing some absorbing topic, transacting some important business, vanquishing some powerful enemy, to waste time upon such a trivial thing as eating; and after a while, when the topic is exhausted, the business accomplished, the foe overcome, she will condescend to dine.

As I have said, when melancholia is the form of insanity, the feeding of your patient is much more apt to be a source of trouble to you. When there is no other hindrance, the general apathy and listlessness will extend to the taking of food, and so embarrass you. But oftener the indifference will give place to absolute resistance. The causes of this are various. Sometimes it is due to the hypochondriacal element, which is so common in melancholia. Then the patient exaggerates her malady and its symptoms. She is beyond the reach of medical aid; her disease is necessarily fatal; why, she argues, give her food only to prolong for a time her terrible agonies? Sometimes the cause is found in more pronounced delusion. The patient thinks that her family and friends are in danger of starvation, and that to consume this food herself will be to deprive them of their last means of subsistence. Such delusions often arise where the insanity takes a religious turn, and they are frequently associated in some way with the recollection of our Lord's fasting in the wilderness. The patient believes that it is necessary, in order to the salvation of her soul, that she should fast for forty days and forty nights. Sometimes, again, the suspicions that the patient has of conspiracies against her life, lead her to refuse food in the belief that it is poisoned, and in other cases there is no delusion at all in relation to the food, but the patient refuses it in the deliberate design to commit suicide by starvation. Perhaps the most troublesome cases are those in which the abstinence is the result of illusion or hallucination. To the distorted vision of the patient the food assumes the form of blood, or excrement, or human remains, and she turns from it in horror or disgust. Similarly her sense of smell may be at fault, or if nose and eyes retain their normal powers, the senses of touch or taste may interfere. Or all these senses may be unaffected, and hallucinations of the hearing—voices of authority commanding her to refrain from food—may deter her.

Any measures that I may describe to you wherewith to meet these obstructions and overcome these delusions,

short of mechanical means to compel the taking of food, will, of necessity, be tried without avail in many cases; but they *should* be tried, and tried faithfully, in every case, for food eaten in the natural way will always be much more efficacious than that forced into the stomach against the patient's will.

In the first place, great attention should be paid to the preparation of the food, and to the manner in which it is placed before the patient—though this is a rule that applies to the nursing of the sick generally, and one that has, no doubt, already been fully urged upon you. When the reluctance to eat comes merely from personal indifference, a well-cooked dinner, neatly served, may awaken the appetite and arouse the patient. Dainty viands, good to the sight and grateful to the smell, will whet the appetite of the insane as well as of the sane.

Where the refusal to eat has its origin in any other of the causes I have named, endeavors to overcome it must partake largely of the nature of argument, and of the efficacy of argument in the treatment of insanity I have already given you my opinion. Still, they should be tried if other means fail. So if your patient is a hypochondriac, you may set to work to convince her that the particular ailment she fancies she suffers from has no real existence. If you argue her out of one disease, she will usually take refuge in another, but she may also take a meal or two in the meantime. If she thinks her family are starving, add demonstration to argument. Show them to her alive and well, and let them join their assurances with yours. If she has the idea of fasting, try what good it will do to quietly lead the way to the consideration that fasting does not imply literal abstinence from all food, but the rejection of certain articles. She may fall in with this, and, religiously abstaining from meat, keep body and soul together on fish and eggs, and so forth. If she thinks she is going to be poisoned, you may do a good deal by tact and judgment, and more still by carefully avoiding all appearance of mystery. If you fuss over her food in a corner like a conspirator, you may expect her to look upon it with suspicion. So let all your movements be open and above board. The food in such cases should be simple and such as not to easily carry out the idea of the possible presence of poison. It will be a good thing to prepare it in her presence as much as possible, and under her inspection; and it may

be feasible to let her purchase and prepare some of it herself. You may use such arguments with her, as that it would be impossible to introduce poison into an egg, the shell of which is unbroken. Finally, if she claims still that her food is poisoned, you may endeavor to convince her to the contrary by yourself partaking of it, and showing her that it has no ill effects upon you; and the first two or three times you try this apparently unanswerable argument, you will probably be astonished to find that it does not convince her at all. She will tell you that your constitution is different from hers, that you have prepared yourself by already taking an antidote, or that, in some mysterious way, the poison is solely directed against her, and will solely affect her, not others. When hallucinations are at the bottom of the refusal, it is almost hopeless to attempt to overcome it in this way, and the same may be said of cases where there is a suicidal motive. In the latter case, to be sure, you might point out the tedious delay that the adoption of starvation as a method of suicide would entail, and delicately suggest recourse to some speedier means, but there are manifest objections to such a course.

You have much more to hope for from persuasion than from argument, and you must understand that by persuasion I don't mean force. You have doubtless heard of the Irish gentleman who considered persuasion to mean knocking down with a club. That is not just my meaning. I think that firmness is very necessary in some cases, and that under its influence a refractory patient may be made to eat, but what I am speaking of now will be perhaps better expressed by the use of the word "coaxing." As I am speaking to ladies, I need scarcely explain what I mean by that—the patient pleading that is tried again and again in spite of rebuffs and refusals. It may succeed by inspiring the patient with confidence, or it may have the same effect indirectly—in other words, the patient may eat in order to escape from your importunities, and return undisturbed to her broodings, somewhat as the lady married the man to keep him from bothering her.

As I told you, the means to which I have referred are not commonly very successful when the determination of the patient is at all considerable. Still they *may* produce some results, and if you try them successively and faithfully, your patient may, in the end, be able to say, as a certain ar[illegible] said before her, "the woman tempted me, and I did eat."

Failing of success in all persuasive measures, our last appeal is to force. Nor should this appeal be long deferred, when once we have become satisfied of its necessity. A patient who is very robust and strong may be allowed to go for a few hours beyond her usual time of eating, upon the chance that she may change her mind, but this should never be done in the case of one who is feeble and reduced.

The method of artificial feeding, and the amount of force necessary to its accomplishment, will vary with different patients and different practitioners. Some will submit to the process unresistingly, others will struggle violently. The ordinary method is to introduce slowly and carefully into the stomach a slender tube of some flexible material, and thus make it the channel for the passage of beef-tea, egg-nogg, or other liquid nutriment. Some prefer to introduce the tube by the mouth, others by the nostrils, though why a man should be fed through his nose, just because he is insane, I have never quite been able to understand. By some the fluid is rapidly forced through the tube with a stomach pump, the action of which is reversed. By others, it is more slowly introduced by means of a funnel. Whichever method is adopted, the physician will probably himself attend to the introduction of the tube and subsequently of the food, unless persistent refusal to eat, and the consequent necessity for prolonged and frequent artificial feedings, lead him to delegate the duty to you. In the former case your office will be to assist in restraining the patient and preparing her for the reception of the tube. Patients who are feeble will generally be fed while they are lying in bed, but this is apt to be an inconvenient business, and where their strength admits of it, it is better to place them in a strong, low chair. The arms are held by an attendant, or confined by a camisole, which may also be made to serve to fasten the patient in the chair, and another assistant takes care of the lower limbs. A third stands behind the patient and holds the head steady, resting the back of it against her breast, and extending a hand over either cheek. This is the position of most importance, and will probably be yours, and it will behove you to keep your nerves steady, and your muscles active, or the Doctor may go home with a bitten tube, or, worse still, a bitten finger. The patient being thus held immovably, the next point is to get the mouth open, and keep it so. To accomplish

this an instrument is used varying in simplicity from a plain wooden wedge, to a contrivance made of iron, which being introduced between the teeth, separates into two blades, as a screw is turned, and so forces the jaws apart. Whatever the instrument used, the opportunity for its insertion is found when the patient opens her or his mouth to talk, an opportunity for which accordingly you will have to wait a longer or shorter time, as your patient is a man or a woman. When the teeth are separated, and the instrument by which they are kept apart is securely held in the Nurse's hand, the physician inserts the tube, guiding it with his forefinger, and the patient is fed easily and comfortably. Often the moral effect of one such feeding is enough to cure all desire on the part of the patient for another such experience. So it should not be thought that because a patient has once been fed artificially, she must so be fed at the next time of asking, but the opportunity should each time be afforded her of returning to the natural mode of eating. Often, too artificial feeding will have no such good effect, but the patient will, either from proneness to new sensations, or objection to the labor of eating when such a labor-saving machine is available, persist in its continuance.

The same difficulties that are encountered in feeding insane patients will be met with in administering medicines to them, and much more frequently, and in a greater degree. Many patients will take their meals regularly from force of habit, and in the absence of delusions which lead them to interrupt it, but they will utterly refuse to take remedies, either because they do not admit that they are sick, and therefore deny their necessity, or because they believe that they are so sick as to be beyond the power of drugs, and that consequently their consumption would be useless and wasteful. You may endeavor to combat this opposition, as in the case of opposition to the taking of food, by perseverance and persuasion. If the patient still refuses, it will be for the physician to decide what is to be done, whether recourse shall be had to stratagem, and the medicine mixed with the food or drink, or whether such remedies shall be chosen as can be conveniently administered by hypodermic injection. When the patient does show a willingness, real or apparent, to pursue the treatment prescribed for her, you must be careful that she is not deceiving you. Do not turn your back and give her the opportunity to throw the

medicine aside, and pretend to you that she has taken it. Watch that she puts it into her mouth, and then keep on watching until you make sure that she has swallowed it, or she may keep it in her mouth until your attention is withdrawn, and then eject it. When medicine is given in pill-form this is particularly likely to be attempted, and particularly easy of accomplishment, for a pill or two can be kept under the tongue for a considerable time, and the patient can go on opening her mouth and talking as innocently as possible. Physicians accustomed to the care of the insane do not, for this reason, often prescribe remedies in the form of pills. Remember, in this matter, that your patient is apt to be very cunning, and that you must not trust her in anything, or take anything for granted, but be on the watch constantly.

You must be very particular in the case of the insane, in making those observations of the patient's condition in the matters of temperature, pulse, secretions, and so forth, which form a part of the Nurse's duty in all cases of sickness. Remember that with such patients no reliance can be placed upon their statements. You cannot look to them to keep you informed as to their feelings and symptoms, rather they will mislead you, if they speak to you of such matters at all. The physician must be guided in his treatment mainly by what is observed by others than the patient. And, as his visits must necessarily be short, he will depend upon you to keep close watch, and make accurate reports. Look particularly to the excretions, their frequency, and the appearance and quantity of the excreta, and be on the watch for bed sores, which are particularly apt to come on in the insane, as in them vitality is much lowered, and there is a degree of restlessness that is very likely to cause abrasions and subsequent sloughs. Watch for the rational symptoms of disease, cough, expectoration and the like. An insane patient may develop a pneumonia, and say no word about any pain, but you may detect its presence by his movements, perhaps, by his putting his hand to his side, or by his changes of position in bed. And pay especial attention to the preservation of due cleanliness, for in this respect the insane are commonly neglectful.

The subject of the restraint of the insane is one that covers a wide extent, from simple attendance upon the patient, while he goes about his usual avocations and pursuits, to close confinement to his room or to his bed. The

first kind is applicable mainly to chronic and quiet cases, and to a class unlikely to come under your care. Those that do so come will ordinarily require restriction to a single room, and possibly, forcible retention in their beds. The force necessary to such restraint may be animate or inanimate, in other words, may be applied by men or women, or by mechanical contrivances. With regard to the latter form a prejudice exists, arising from the fact that at one time mechanical restraint was no doubt too generally had recourse to, and with undeniably evil results. The general tendency to rush to extremes, which is shown in matters of medical practice as well as in other human affairs, prompted the conclusion that because the use of mechanical restraint in excess was harmful, therefore it should be abandoned altogether. From this extreme again, there has been a re-action, and at the present day the most experienced in the treatment of the insane, as a general rule, agree that the application of mechanical restraint in certain cases, and with due care, is not only permissible, but humane.

As to the relative merits of restraint by instruments and restraint by physical force, the privilege to differ, which is traditionally conceded to doctors, is freely exercised. One will tell you that a patient will suffer unnumbered agonies if confined in a strait-jacket, while restraint at the hands of attendants will soothe and benefit him, and another will tell you just the reverse. In this matter of detail, as in the whole question of restraint, I hold a middle course to be the best. I do not believe in classing all insane men and women together, and treating them according to pattern. It should be a question of individuals, and the method of restraint, like all the means of treatment, should be selected with a special view to, and after a careful study of, the exigencies and idiosyncrasies of each particular patient. Thus one man will resist to the utmost of his power the personal interference of his attendants, while, after satisfying himself by a few ineffectual struggles of the strength of a pair of handcuffs, he will submit to wear them with the best possible grace. Another will be docile and obedient under the hands of an attendant, and will wear his strength away in the effort to remove a strait-jacket. So you must observe the peculiarities of each patient, and choose that method of restraint, and apply it in that manner which will be least galling to her. If the locking

of the door irritates her, leave it open, and try to keep her in the room by persuasion, and gentle personal resistance.

It will not be necessary or advisable to enter here upon any lengthened description of the different kinds of restraining apparatus, and the manner in which they are to be applied. Without practical exhibition of them it would be difficult to make you comprehend their forms and purposes, and the method of their application. The camisole, or strait-jacket, is the appliance in commonest use, and is simply a jacket of sail-cloth or other stout material, made to fit the body closely, and fastening up the back. The sleeves, instead of terminating like an ordinary sleeve at the wrist, are prolonged for three or four feet, and the ends being carried around the waist and there tied, the patient is unable to use his hands or to extricate himself. Muffs, wristlets and other such articles are generally made of sole-leather, and are applied with the same object as the camisole. The crib-bed is a sort of cage in which wooden bars or slats form a top and sides to the bed, and prevent the patient escaping from it, while they force him to retain a recumbent position. This is chiefly useful, not so much for violent patients as for those who are restless and inclined to wander about, or those who are prone to rise from their beds and stand for hours at the window or against the wall. Forced to lie down, they get a certain amount of rest, if they do not sleep; and sleep is more likely to overtake them when the head is lowered and the brain suffused with blood.

Such are the considerations regarding the nursing of the insane, which the limits imposed by time and circumstances will permit me to present to you. The fact that the honor has been done me of selecting me to deliver the opening lecture of this course, seems to render it proper that I should supplement them by some remarks more general in their application, and so I further tax your patience and avail myself of the privilege which our meeting gives me, to add my meed of encouragement and wish you God-speed in the calling which you have adopted. In common with others of my profession, the faults and failures of the average nurse have at times brought me tribulation and discouragement. In common with them, also, I see in the

establishment of your school a measure from which we may reasonably hope for much of good. To the Commissioners, whose foresight and liberality have inaugurated the system, to Dr. Kitchen, who has so ably carried out their intentions, and to yourselves no little credit is due that, from an experiment, the school has already passed to a measurable success. But much remains before you, and when your studies here shall have been finished, the test will only be beginning as you carry the knowledge and experience you have gained into the world. Persevere, then, in mastering the details of your office, and especially in the cultivation of those qualities of mind and motive which alone can enable you to properly perform them. The career that is before you is intrinsically neither an easy nor a pleasant one. Few are more arduous, less remunerative, more thankless; and the motive which prompts you to its commencement, must be another and a better one, than that which leads to the adoption of more inviting professions. And as your motive differs, so will your reward. You will not find it in affluence or fame, but in the gratitude of the suffering and the dying, the approval of your own consciences, and, above all, in the approbation of Him, who, quick to own a common brotherhood with all the sinful and the afflicted, quick too, to own a common obligation for all kindness and humanity, says to the doer of the simplest act of charity and mercy — "Inasmuch as ye have done it unto one of the least of these my brethern, ye have done it unto me."